True Decisions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Case Number:

Date of Notice: 10/16/2015

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Anterior Lumbar Fusion @ L5/S1 with 1 day inpatient stay

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a female who was injured on xx/xx/xx while xxxxx. The patient described complaints of low back pain radiating to the lower extremities. The patient had previously been treated with physical therapy and did complete a work conditioning program through December of 2014. It is noted that previously recommended lumbar spinal fusion in 2014 for which the patient did undergo a psychological evaluation on 03/10/14 – 03/19/14 which found no contraindications for surgery. The last MRI study of the lumbar spine was completed on 09/16/13 which noted a midline annular tear at L5-S1 with significant foraminal encroachment and associated central stenosis. Medications have included Norco, Celebrex, Zanaflex, Ultracet, Naproxen, and Tramadol. The most recent assessment for this patient was from on 06/03/15 which still noted complaints of back and lower extremity pain. The patient did not improve with conservative management. The patient's physical examination was limited to vital signs only. The patient was again recommended for a lumbar spinal fusion at L5-S1.

The proposed surgical requests were denied by utilization review on 06/22/15 as there was no documentation regarding a psychological assessment or evidence regarding spinal instability.

The request was again denied by utilization review on 08/14/15 as there was no clear imaging evidence of instability to support the medical necessity of the request. With peer-to-peer discussion, was documented as not providing further evidence to support the request.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient has been followed for chronic complaints of low back pain radiating to the lower extremities. The patient did not improve with conservative treatment to include physical therapy, work hardening, or medications. The clinical documentation available for review includes out of date MRI studies of the lumbar

spine from 2013 which found evidence of stenosis due to disc pathology. There were no updated imaging studies showing any clear evidence of motion segment instability, severe spondylolisthesis, or complete collapse of the disc space which would meet guideline recommendations regarding the proposed lumbar spinal fusion at L5-S1. The patient's most recent assessment with did not include any specific physical examination findings. Given the paucity of updated clinical imaging as well as the lack of specific physical examination findings for this patient, it is this reviewer's opinion that medical necessity has not been established based on guideline recommendations for lumbar spinal fusion. Therefore, the prior denials remain upheld. As the surgical request for the patient is not indicated, the requested 1 day inpatient stay would also not be medically necessary and the prior denial for this portion of the request is also upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back
- ☐ Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)